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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning 5x/week x 2 weeks x 4 hours daily (CPT 97545)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who reportedly developed right hand pain and finger numbness/tingling after repetitive lifting of boxes in xx-xx-xx. She subsequently was felt to have carpal tunnel syndrome and ulnar neuropathy based upon the electrodiagnostic studies. She underwent surgery on 12/2/08. She had 11 sessions of postoperative therapy over 10 weeks. She was working and reported ongoing wrist pain (3-4/10) and finger numbness that increased when she was lifting a 50 pound box. Her job description described constant 5 pounds of lifting, 10 pounds frequently and occasionally 20 pounds or more. Her FCE on 2/24 showed persistent tingling and numbness with finger pain. The current request is for Work Conditioning 5x/week x 2 weeks x 4 hours daily (CPT 97545).

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

It would appear from the medical records reviewed that this patient's ongoing symptoms of finger pain and numbness are the main symptom limiting factors in the FCE testing. She was able to lift 50 pounds at work, although she had more pain.

The ODG recognizes the need for 3-5 therapy sessions after an open CTS release or 3-8 sessions over 3-5 weeks following an open CTS release. The ODG addresses the role of Work Conditioning in building up the functional reserves (upper extremity section.) This claimant has mainly neurological symptoms (numbness and pain) from the activity. As per the ODG, it is unlikely that the work conditioning, which addresses aerobic capacity and strength, would be the adequate treatment program for this patient. Rather, the records indicate her symptoms may persist with the work conditioning, just as they have after her 11 therapy sessions. There does not appear to a valid reason provided in the medical records to justify the work conditioning program as opposed to a modified work program. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for Work Conditioning 5x/week x 2 weeks x 4 hours daily (CPT 97545).

Physical/Occupational Therapy: A short course may be appropriate; if so then Post-surgical treatment of 3 to 5 visits.

Physical medicine treatment

Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is an effective operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments. See also more specific physical therapy modalities

ODG Physical Medicine Guidelines –

Allow for fading of treatment frequency, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface

Carpal tunnel syndrome (ICD9 354.0)

Medical treatment: 1-3 visits over 3-5 week

Post-surgical treatment (endoscopic): 3-8 visits over 3-5 week

Post-surgical treatment (open): 3-8 visits over 3-5 weeks

Recommended as indicated below. Carpal tunnel syndrome seems to be primarily attributable to CTS-prone personal characteristics (e.g., obesity, diabetes, female, smoking), but symptoms may be associated with workplace activities. (Melhorn, 2008) (Lozano- Calderon, 2008) Some controversy continues about whether computer work is a risk factor for CTS, with current opinion that the keyboard is low risk and that the mouse may be mild risk. There is some evidence to conclude that CTS symptoms are associated with workplace activities, but current studies have not proven a causal relationship. (Nathan, 1993) (Lam, 1998) (Nordstrom, 1997) (Moore, 1997) (NIOSH, 1992) (Stevens-Mayo, 2001) (Denniston, 2001) (Andersen-JAMA, 2003) (WCB-Alberta, 2003) (Falkiner, 2002) (Nathan, 2002) (Dias, 2004) (Wellman, 2004) (You, 2004) (Boz, 2004) (Geoghegan, 2004) (Landau, 2005) (Bonfiglioli, 2006) (Melchior, 2006) (Derebery, 2006) (Werner, 2006) Microbreaks from repetitive motion jobs show positive, limited evidence. Limitations of keyboard work or pinch grasping may be a reasonable option during the first few weeks after onset of symptoms. There is evidence that keyboard users may experience a reduction in hand pain after several months of use of some alternative geometry keyboards, although the benefit appears to be user preference. Activities that aggravate symptoms include: (1) repetitive or prolonged wrist movement, especially if forceful (e.g., keyboarding, butchering, assembling, hammering, buffing, grinding, sanding, scrubbing, packing, sorting mail, wringing laundry, opening jars, knitting, turning a key, gripping a doorknob, playing a musical instrument, etc.); (2) localized mechanical stresses (e.g., prolonged pressure over the wrist or palm); (3) exposure to excessive vibration (e.g., a jackhammer, chainsaw); and (4) prolonged exposure to cold temperatures (e.g., handling cold parts). (Mclean, 2001) (Rempel, 1999) (Tittiranonda, 1999) Although obesity and gender are consistent predictors of CTS, workplace demands appear to bear an uncertain relationship to CTS. (Nathan, 2005) Regarding preplacement nerve testing for CTS, not hiring workers with abnormal post-offer preplacement median nerve tests to reduce costs of work-related CTS is not a cost-effective strategy for employers. (Franzblau, 2004) (Werner, 2006) And genetic testing is not recommended. (Schulte, 2003) High force with repetitive work was associated with a higher level of CTS and abnormal NCS. These findings appeared to be reversible following a period of less repetitive work. Prevalence of CTS was significantly higher in assembly line workers compared to non-assembly line workers. (Bonfiglioli, 2006) A recent study of wrist posture, loading and repetitive motion as risk factors for developing carpal tunnel syndrome, found that frequent flexion (OR 4.4), frequent extension (OR 2.7), and sustained forceful motion (OR 2.6) were associated with CTS, but neutral wrist position and repetitive wrist motion were not associated with CTS. (Fung, 2007) See also Return to work

ODG Capabilities & Activity Modifications for Restricted Work

Modified work: Repetitive motion activities limited to 4 hours or less per 8-hour day broken into periods of 1-hour regular activities and 1 hour of alternate activities, repeated for the workday. Avoidance of prolonged periods in wrist extreme flexion or extension.

Regular work (if not aggravating symptoms): Repetitive motion activities limited to 6 hours or less per 8-hour day broken into periods of 1-1/2 hour regular activities and 30 minutes of alternate activities, repeated for the workday. Avoidance of prolonged periods in wrist extreme flexion or extension.

Work conditioning, work hardening

Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. (Schonstein-Cochrane, 2003) There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip,

knee, shoulder and forearm. (Karjalainen, 2003) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. (CARF, 2006) (Washington, 2006) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-Cochrane, 2008)

Criteria for admission to a Work Hardening Program

- (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA)
- (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning
- (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function
- (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week
- (5) A defined return to work goal agreed to by the employer & employee
 - (a) A documented specific job to return to with job demands that exceed abilities,
 - (b) Documented on-the-job training
- (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program
- (7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit
- (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less
- (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities
- (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury

12 visits over 8 weeks

See also Physical therapy for general PT guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)